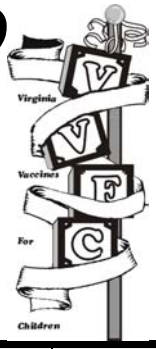
VACCINE ADMINISTRATION AND SCREENING RECORD



Patient Name:_____

Date Of Birth: _____

Medical Chart Number: _____

Physician: _____

Practice Address:

VACCINE Indicate Vaccine Administered	Date M/D/Y	*VVFC Eligibility Screening	Vaccine Manufacturer	Vaccine Lot Number	Site (Optional)	Expiration Date M/D/Y (Optional)	Initials Of Vaccine Administrator	Vaccine Information Materials Date	Initials of Parent or Guardian (Optional)
DT / DTaP 1									
DT / DTaP 2									
DT / DTaP 3									
DT / DTaP 4 / DTaP-Hib 4									
DT / DTaP 5									
Hib 1									
Hib 2									
Hib 3									
Hib 4 / DTaP-Hib 4									
Hep B 1 / Hep B-Hib 1									
Hep B 2 / Hep B-Hib 2									
Hep B 3 / Hep B-Hib 3									
IPV 1 / DTaP-Hep B-IPV 1									
IPV 2 / DTaP-Hep B-IPV 2									
IPV 3 / DTaP-Hep B-IPV 3									
IPV 4									
Pneumococcal 1									
Pneumococcal 2									
Pneumococcal 3									
Pneumococcal 4									
MMR 1									
MMR 2									
Varicella 1									
Varicella 2									
Td 1									
Td 2									

* ELIGIBILITY SCREENING

Patients should be screened each visit prior to immunization. Use free vaccine on eligible patients only.

VVFC eligible because they are less than 19 years old and,

M = Child has Medicaid
U = Child is Uninsured
A = Child is American Indian or Alaskan Native
I = Insurance does not cover immunizations

Not eligible for VVFC and,

S = Private insurance, school required vaccine
AD = Adult Immunization (IPV, MMR, Td Only)

SIGNATURE OF VACCINE ADMINISTRATOR (S)
If more signatures are needed use the back of this sheet

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

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